CIRCULAR LETTER: DHCQ 5-97-363

To: Administrators of Long Term Care Facilities

From: Paul Dreyer, Ph.D., Director

Date: May 15, 1997

Re: Guidelines for the Use of Restraints in LTCFs

The purpose of this circular letter is to provide you with the Department's guidelines for the use of restraints. Over the past year, Department staff, long term care facility providers, MECF staff and HCFA representatives have been meeting to develop consensus around the use of restraints, and particularly, the use of siderails as restraints. The attached document is the result of our combined effort.

We believe this guideline clearly describes the context within which a device is to be considered a restraint. It is expected that any device be evaluated for any resident, to determine its appropriate use. When the device is a restraint, then the evaluation must be a complete restraint assessment. If you have any questions, please call Kathleen Coyle, Assistant Director/Survey Operations, at (617)727-5860.

Guidelines for the Use of Restraints in Long Term Care Facilities

483.13 Resident Behavior and Facility Practices

"The resident has the right to be free from any physical or chemical restraint imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."

What is a physical restraint?

To be a physical restraint, a device must meet the following two criteria:

1. the device actually restricts the resident's freedom of movement or access to his/her body; *and*
2. the intended use is to restrict the movement of the resident in some way.

What is a chemical restraint?

To be a chemical restraint, a psychoactive drug must meet the following criteria:

1. the psychoactive drug is used for discipline or convenience to reduce certain behaviors, *and*
2. the drug is not required to treat medical symptoms.

Note: The use of a psychoactive drug to appropriately treat active psychosis, such as hallucinations, would not be considered a restraint. *An accurate differential diagnosis is necessary to discover the root cause of the undesirable behavior.*

MDS and Care Planning

It is expected that any device be evaluated for any resident to assure its appropriate use. When the need to restrain a resident is identified, the multidisciplinary team, in conjunction with the resident and family members, must develop and implement a plan for the least restrictive therapeutic intervention necessary to treat specific medical symptoms; and, if such intervention is a chemical or physical restraint, that plan must include steps to reduce its use over time.

Assessment: The assessment should reflect use of the RAP guidelines for physical restraints and/or psychotropic drug use, when these are triggered on the MDS. Although siderails don't trigger for an assessment on the MDS, a restraint assessment must be done when siderails are considered for use as a restraint. Included in the assessment are: the medical symptoms to be treated with a restraint, the causes of those symptoms, risk factors, interventions, other than restraints, which have been, or should be tried to treat the symptoms, and the selection of the least restrictive restraint.

Plan: The plan must include a physician's order for the restraint, and should indicate who, what, when, where and why. A description of the specific time and circumstances for restraint use will

assure the provision of the services necessary to enhance the resident's life, prevent complications, and keep restraint use at a minimum.

Monitoring: Ongoing monitoring must address the proper application and use of the restraint, track the resident's response, both positive and negative, to restraint use, including the development of complications.

Re-evaluation: Periodic re-evaluation, no less often than quarterly, must assess whether there is the continuing need for the restraint, and if so, whether a reduction in the time and/or circumstances requiring its use, and/or a less restrictive restraint device, is possible. The primary criteria used in assessing a restraint is that it is an effective intervention in assisting the resident to achieve and/or maintain his/her highest practicable level of well-being.

Important Considerations in the Selection and Use of Restraints

Goal of Restraint Use

The effect of the restraint should be positive and enabling, permitting the resident to improve or maintain, as much as possible, his/her abilities to perform ADLs and participate in the life of the nursing home.

Resident or Family Requests for a Restraint

A surrogate decision-maker cannot authorize use of a restraint, as previously defined , *in the absence of* an assessed medical symptom. Restraint use in the absence of an assessed medical symptom even if requested by a surrogate decision-maker, may be cited as a deficiency, if its use meets the definition of a restraint, even when the facility can document ongoing efforts to educate the family/surrogate decision-maker.

(This is consistent with Health Care Proxy legislation which recognizes surrogate decision-makers' authority to accept or refuse treatment on behalf of the resident, but not to prescribe treatment.)

Siderails/Bedrails

HCFA has clarified its position on the use of siderails in nursing facilities:

"Side rails may be appropriate when used to assist the resident maintain or attain his or her highest practicable level of physical, mental and psychosocial functioning. The decision regarding whether to raise side rails needs to be made after clinical evaluation at the bedside and interdisciplinary care planning. The purpose for that intervention must be determined. That is, if the purpose is either to facilitate in-bed mobility and /or transfer, the side rails are not being used for the purpose of restraining the resident. If the purpose and effect of the side rail is to prevent a resident from getting out of bed when that resident wants to get out of bed, then side rails are being used as restraints..."

(from Memorandum dated Feb. 10, 1997, from Robert Streimer, Acting Deputy Bureau Director for Survey and Certification, Health Standards nad Quality: Side Rails Interim Policy)

When an alert, oriented resident requests siderails, the facility may honor the request. This use of siderails is not considered a restraint, but the practice needs to be re-evaluated periodically to ensure that the continued use of the device does not place the resident at increased risk for injury.

The resident, who is in a persistent vegetative state, or who is incapable of purposeful movement, may have siderails that are not considered restraints because the siderail does not restrict the resident's movement in some way.

MDS would be coded "4: total dependence" under "G:a:bed mobility"

In order to determine that a siderail is a "psychological restraint", there must be an observed resident response to the siderail usage, e.g., increased agitation. Periodic re-evaluation of the resident's plan of care must include an evaluation of the psychological impact of the siderail.

Note: the HCFA 672 "Resident Census and Condition of Residents" , item F104 - should not include residents whose siderail is not used as a restraint.

Family Involvement

Involve families in the assessment and care planning process. Families can best describe the resident's "customary routine" which can be utilized in identifying ways to minimize restraint use and possibly identify least restrictive restraint devices.

Encourage ongoing communication between family members and staff.

Establish a mechanism for addressing family complaints and concerns.

Other Important Considerations

RESTRAINT USE SHOULD HAVE A POSITIVE AND ENABLING EFFECT ON THE RESIDENT.

Planned Program

- Each facility must establish a Restraint Reduction Program, and articulate a corresponding philosophy of care which involves all staff in promoting a "restraint appropriate" environment.
- Everyone in the facility needs to know about, and "buy into" the Restraint Reduction Program.
- There must be increased availability of physical, creative, social and spiritual activities for the residents.
- Evaluation of staffing patterns and staff expertise must be considered in the implementation of the Program.

Environmental Considerations

- Allow for wandering: closed unit or area; alarms.
- Use of color, increased lighting.
- Decrease sound levels.

Planned Interventions

- Individual health, functional and psychosocial problems which may be causing the condition fro which restraints are ordered (e.g., falls, wandering, cognitive deficits, agitation) must be identified and treated.
- Address expressions of pain, toileting needs, and maintain the individual's customary routine.
- Use least intrusive measures in the delivery of patient care services.
- Provide meaningful activities and regular exercise.
- Provide psychosocial support.

Education

- Staff must have the expertise to identify and promote appropriate care management alternatives.
- Education about restraint use and reduction should be ongoing, and involve the resident , the family and the facility staff.